Appendix 7
Prior Authorization Request Form (PA/RF) Instructions

Element 1 - Processing Type
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. *Use 999 - "Other" only if the requested category of service is not found in the list.* Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

130 - Durable Medical Equipment
132 - Disposable Medical Supplies
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number as found on the recipient's identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address and Zip Code
Enter the name and complete address (street, city, state, and zip code) of the billing provider. **No other information should be entered in this element since it also serves as a return mailing label.**

Element 8 - Billing Provider's Telephone Number
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the *billing provider.*

Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the billing provider.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis *code and description* most relevant to the service/procedure requested.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

Element 12 - Start Date of Spell of Illness (not required)

Element 13 - First Date of Treatment (not required)

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element.

Element 15 - Modifier
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 - Place of Service
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested.

Alpha	Description
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
P	Purchase New DME
R	DME Rental

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)
Durable Medical Equipment (number of services)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)

Element 20 - Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Social Services.

Element 21 - Total Charge

Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement

"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid managed care program at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the managed care program."

Element 23 - Date

Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider -- this space is reserved for the Medicaid consultant(s) and analyst(s).